FASTFORM

Group Hospital Indemnity Insurance Plan
Guaranteed Acceptance

Complete this form and return to:
Insurance Specialists, Inc.
PO Box 588, Beaufort, SC 29901
(888) 474-1959

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY 10010

1 MEMBER INFORMATION

Please Print In Ink Or Type.

Name _____
First Middle Last

Home Address _____

City _____ State _____ Zip _____

Email Address _____ Home Phone _____ Cell Phone _____

Date of Birth _____ Social Security No. _____ Gender _____

☐ **I am a member of an Association affiliated with the Insurance Specialists, Inc. Insurance Trust.**

Name of Association: _____

2 INSURANCE REQUESTED (Refer to the product summary for eligibility and coverage description)

I hereby apply for the following coverage(s):

Hospital Indemnity Insurance *(Up to $400 Daily Benefit in $100 Units)*

☐ Member Daily Benefit $ _____

☐ Spouse Daily Benefit $ _____

☐ Child(ren) Daily Benefit $ _____

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Social Security Number	
			☐ Male ☐ Female

Name of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Social Security Number	
			☐ Male ☐ Female
			☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your application.

3 BILLING

Payment Information

Send no money now — you will be billed if approved for coverage.

Bill Me:

☐ **Annually** ☐ **Semiannually** ☐ **Quarterly**

If billing choice is not made, you will automatically be billed Quarterly.

☐ **Monthly**

If you select Monthly billing, you will be sent an ACH Authorization Form to complete.

4 FRAUD NOTICES

For Residents of all states except those listed below: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO:** *the following also applies:* Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **RESIDENTS OF AL/AR/LA/RI:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **RESIDENTS OF CA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **RESIDENTS OF D.C.: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **RESIDENTS OF FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **RESIDENTS OF KS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law. **RESIDENTS OF ME:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **RESIDENTS OF MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **RESIDENTS OF NJ: WARNING:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **RESIDENTS OF NY:** *For accident and health insurance only*, any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **RESIDENTS OF OK: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **RESIDENTS OF TN/WA:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **RESIDENTS OF VA:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

2.2023 ed

5 AUTHORIZATION

READ AND SIGN:

By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance attest to having read the Fraud Notices indicated above and that to the best of my knowledge and belief, the answers to the questions are true and complete.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Member's Signature (Please Sign and Date in Ink)	Print Name	Date Signed (MM/DD/YYYY)
Spouse's Signature (Necessary Only if Spouse Coverage is Requested)	Print Name	Date Signed (MM/DD/YYYY)